

3901 DUTCHMANS LANE
SUITE 105
LOUISVILLE, KY 40207
OFFICE: 1-888-442-4325

PLEASE FAX FORM TO

502-540-8998



SERENITY HEALTH

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PATIENT INFO FOR KETAMINE INFUSION/ SPRAVATO/ MEDICATION

Date: _____	Patient Name: _____
Referring Provider: _____	Patient DOB: _____
Referring Provider Phone: _____	Diagnosis: _____
Patient Phone: _____	

Check all that apply:

<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> ANXIETY	<input type="checkbox"/> PTSD	<input type="checkbox"/> PAIN	<input type="checkbox"/> SUICIDAL THOUGHTS
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PLEASE SUBMIT THE FOLLOWING DOCUMENTATION WITH FORM

<input type="checkbox"/> PATIENT DEMOGRAPHICS	<input type="checkbox"/> COPY OF MOST RECENT LABWORK (WITHIN LAST 6 MONTHS)
<input type="checkbox"/> COPY OF PATIENT INSURANCE & ID CARDS	<input type="checkbox"/> IMAGING & PRIOR TREATMENTS RELATED TO CONDITION FOR BEING SEEN
<input type="checkbox"/> MOST RECENT OFFICE NOTE INCLUDING CURRENT MEDICATION LIST & DIAGNOSIS	

REASON FOR BEING SEEN:

PROVIDER SIGNATURE: _____ DATE: _____